THE MEDICAL SECURITY PROGRAM

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF UNEMPLOYMENT ASSISTANCE

REQUEST FOR INDEPENDENT EXTERNAL REVIEW OF A HEALTH INSURANCE GRIEVANCE

This request must be filed with the Medical Security Program (MSP) at the Department of Unemployment Assistance (DUA) within four months of the patient's receipt of written notice of the final adverse determination.

If you plan to request an expedited review, please read pages 7–9 immediately and complete and return the entire form.

PATIENT INFORMATION	
1. **Patient's name:**	
2. **Mailing address:**	
3. **Daytime telephone:** (Please list the number(s) where we can reach you from 9:00 a.m. to 5:00 p.m.)	( )
INFORMATION ABOUT THE PATIENT'S HEALTH INSURANCE COVERAGE	
4. **Policyholder's name:**	
5. **Patient's insurance ID Number:**	
6. **Name of health insurance company:**	
7. **Person at health insurance company involved with your appeal:**	

8. **Describe the disagreement with your health plan and, if possible, indicate the services being denied. Attach additional pages if necessary. You must also attach any information you received from your health plan concerning the denial, and any additional information from your physician that you want the external reviewer to consider.**

_____

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Revised December 2011

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INFORMATION ABOUT YOUR TREATING HEALTH CARE PROVIDER	
8a. **Name of the health care provider who ordered the service that is the subject of the dispute with your insurer:**	
8b. **Type of provider:**	☐Physician ☐Other (please specify): _____
8c. **Provider mailing address:**	
8d. **Provider phone number:**	( )

9. **You can represent yourself, or may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.**

Fill out the section below only if someone else will be representing you in this review.

I hereby authorize _____ to pursue my external review on my behalf.

_____ _____

*Signature of patient (or legal representative)** *Date*

***Please identify:**

☐ Parent ☐ Guardian

☐ Conservator ☐ Other (please specify): _____

Address of Authorized Representative:

_____

_____

_____

Phone number of Authorized Representative:

Daytime: ( )_____

Evening: ( )_____

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REQUEST FOR EXTERNAL REVIEW AND RELEASE OF MEDICAL RECORDS

The Department of Unemployment Assistance (DUA) or an independent governmental entity will randomly assign your case to one of three agencies for external review. This will authorize the release of medical records to the agency that will conduct the review. This authorization may be revoked at any time by writing to the Medical Security Program at the address on page six, but information previously released in reliance upon the authorization will not be affected by the revocation.

I _____, hereby request an external review of the matter described on page 2 of this application. I attest that the information provided in this application is true and accurate to the best of my knowledge.

I authorize my HMO, health insurer or providers to release all relevant medical or treatment records related to the matter described in this request for external review to the external review agency named by the DUA to review my request. I understand that the external review agency will review my medical records to make its decision, and that without my authorization, the agency will be unable to review my request.

This release is valid for six months from _____ (today's date).

I understand that the external agency may not be covered by federal privacy laws.

_____ _____

*Signature of patient (or legal representative)** *Date*

***Please identify:**

☐ Parent ☐ Guardian

☐ Conservator ☐ Other (please specify): _____

Please note: If the patient is over 18, he or she must sign pages 3 and 4. Parents or other family members cannot authorize the release of another adult's records.

Authorization form continues on page 4

PERMISSION ABOUT SPECIFIC HEALTH INFORMATION

Please put your initials if you are authorizing the release of any of the following information:

____ I specifically give permission, as required by M.G.L. c. 111, § 70F, to release information in my record about HIV antibody and antigen testing, and HIV/Aids diagnosis or HIV/Aids treatment, to the external review agency.

____ I specifically give permission, as required by M.G.L. c. 111, §70G, to release information in my record about my genetic information to the external review agency.

____ I specifically give permission to release information in my record about alcohol or drug treatment to the external review agency. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

_____ _____

*Signature of patient (or legal representative)** *Date*

***Please identify:**

☐ Parent ☐ Guardian

☐ Conservator ☐ Other (please specify): _____

AUTHORIZATION TO REFER CASE TO ANOTHER STATE AGENCY

The Department of Unemployment Assistance (DUA) may wish to refer this case, including medical records released by this authorization, to the Massachusetts Division of Insurance or the Office of the Attorney General for further investigation and possible action against the insurer.

I understand that other state agencies may not be covered by federal privacy laws, and that they may be able to further share the information that is given to them. (Note, however, that medical records are exempt from disclosure under the Massachusetts public records law (M.G.L. c. 4, § 7(26)(c).)

Please check one of the following:

☐ I give my permission to DUA to refer my case to the Division of Insurance, the Office of the Attorney General or another relevant state agency.

☐ I do not give my permission to DUA to refer my case to another state agency.

☐ Please call me to discuss the referral of my case to another state agency. I understand that you will need my written permission to share medical information.

_____ _____

*Signature of patient (or legal representative)** *Date*

***Please identify:**

☐ Parent ☐ Guardian

☐ Conservator ☐ Other (please specify): _____

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Please note: Federal law requires this separate authorization form for the release of medical records that are psychotherapy notes. Complete this form only if you are requesting review of a claim for mental health services.

REQUEST FOR EXTERNAL REVIEW AND RELEASE OF PSYCHOTHERAPY NOTES

The Department of Unemployment Assistance (DUA) will randomly assign your case to one of three agencies for external review. This will authorize the release of psychotherapy notes to the agency that will conduct the review. This authorization may be revoked at any time by writing to the Medical Security Program at the address on page six, but information previously released in reliance upon the authorization will not be affected by the revocation.

I _____, hereby request an external review of the matter described on page 2 of this application.

I authorize my HMO, health insurer or providers to release all relevant psychotherapy notes related to the matter described in this request for external review to the external review agency named by DUA to review my request. I understand that the external review agency will review my medical records to make its decision, and that without my authorization, the agency will be unable to review my request.

This release is valid for six months from _____ (today's date).

I understand that the external agency may not be covered by federal privacy laws.

_____ _____

*Signature of patient (or legal representative)** *Date*

***Please identify:**

☐ Parent ☐ Guardian

☐ Conservator ☐ Other (please specify): _____

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WHAT TO SEND AND WHERE TO SEND IT

Please be sure your request includes all of the following:

☐ This completed application form.

☐ A copy of the final adverse determination***** from your health insurer (not necessary if you are filing a request for expedited external review at the same time that you are filing a request for expedited review with the insurer).

☐ A photocopy of your insurance card or other evidence that you are insured by the health insurance company named in this application.

☐ Any medical records, statements from your treating health care providers, or other information that you would like the independent review agency to consider in reviewing your case.

If you need assistance in completing this form, or do not have one or more of the above items and would like information on alternative ways to complete your request, please call the Medical Security Program at 800-908-8801.

Mail the application to:
Medical Security Program
P.O. Box 146758
Boston, MA 02114-0020

Applications requesting an expedited review should also be faxed to MSP at 617-626-5538. After faxing your expedited external review request, please call 800-908-8801 to advise MSP that a request has been faxed.

MSP will screen your request to verify that all information is complete, that your request relates to a final adverse determination from a health insurer (unless you are filing a request for expedited external review at the same time that you are filing a request for expedited review to the health plan), and that the requested service is not specifically excluded from coverage in your health plan evidence of coverage. If your case is eligible, it will be sent to one of the independent review agencies, as described above. The external review agency will complete its review within four business days for expedited requests and 60 calendar days for all other requests. If you have any questions about the review process, please call MSP at 800-908-8801.

***A *final adverse determination** is the written notice from your health insurer telling you that:*

- *your claim is being denied based on medical necessity, appropriateness of health care setting and level of care, or effectiveness of treatment, and*
- *you have exhausted the insurer's internal appeals process*

This completes the application process unless you are requesting an expedited review.

If you are requesting an expedited review, please complete the entire application (pages 1–9).

REQUEST FOR EXPEDITED REVIEW

(Please be sure to additionally complete pages 1-6)

Massachusetts law permits a patient to request an expedited external review in the event of a serious and immediate threat to the patient's health. Any request for an expedited external review must contain a certification, in writing, from your physician (MD or DO) that delay in the provision or continuation of health care services that are the subject of a final adverse determination would pose a serious and immediate threat to the health of the patient.

If this is a request for an Expedited Review, a physician must complete pages 8 and 9, labeled "Physician Certification for Expedited External Review." You must provide the form to your physician, and the physician must fax the completed form to the Medical Security Program (MSP).

I sent the form to my physician. Please check one:

☐ By Mail ☐ By Fax ☐ Other (describe) _____

_____

☐ I did not send the form to the physician. (Please explain:) _____

_____

Name of Physician:	
Address:	
Telephone Number:	( )

REQUEST TO HAVE COVERAGE CONTINUE DURING THE EXTERNAL REVIEW

Massachusetts law states that if the subject matter of the external review involves the termination of ongoing services, the patient may apply to the external review agency to seek the continuation of coverage for the terminated service during the period the review is pending. **Any such request must be made before the end of the second business day following receipt of the final adverse determination from the insurer.** The review agency may order the continuation of coverage or treatment where it determines that substantial harm to the patient's health may result if the coverage or treatment is not continued or for other good cause as the review agency determines. Any such continuation of coverage will be at the insurer's expense regardless of the final external review determination.

☐ I am requesting continuation of services that were previously authorized by the insurer.

_____ _____

Signature of patient or authorized representative *Date*

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PHYSICIAN CERTIFICATION FOR EXPEDITED EXTERNAL REVIEW

A patient or the patient's authorized representative, if any, may request an expedited external review if the physician who ordered the services certifies that delay in the provision or continuation of health care services that are the subject of a final adverse determination would pose a serious and immediate threat to the health of the patient.

The physician must complete this certificate and immediately fax it to MSP at 617-626-5538 in order for a patient to be eligible for an expedited external review of a medical necessity determination. **The patient must complete pages 1–7 as well. MSP cannot consider any request for external review until the entire application is received.**

Name of patient: _____

Patient's phone number: _____

Patient's health plan member ID Number: _____

Name of physician completing this form: _____

Address: _____

_____

_____

Contact person: _____

Phone number: ( )_____

Fax number: ( )_____

An expedited decision is necessary because a delay in providing the recommended health service would pose a serious and immediate threat to the health of the patient.

☐ YES ☐ NO

(Continued on next page)

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If yes, explain the nature of the serious and immediate threat to the health of the patient:

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____

Physician's name

_____

Signature

_____

Date

Physician’s office stamp:

Fax this completed certificate to 617-626-5538.
Pages 1-7 can be faxed with this certificate or may be sent separately but the request cannot be processed without a complete application.

If you have any questions, please call the Medical Security Program at 800-908-8801.

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